

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT TACOMA

RALPH W. CLOSE and LAURA A. LARSON,
individually as parents of the decedent JAMES
ROBERT CLOSE,

Plaintiffs,

v.

PIERCE COUNTY, WASHINGTON; PIERCE
COUNTY SHERIFF PAUL PASTOR; STEVE
PARR, EDWARD CORRELL; JOSEPH
GORMAN; and TODD KLEMME;

Defendants.

No. _____

COMPLAINT FOR DAMAGES AND
JURY DEMAND

Plaintiffs Ralph W. Close and Laura A. Larson, parents of their deceased son, James

Robert Close, claim as follows:

I. PARTIES

1.1 Plaintiffs.

1.1.1 Ralph W. Close is an adult citizen and resident of Clallam County,

Washington in the Western District of Washington.

1.1.2 Laura A. Larson is an adult citizen and resident of Clallam County,

Washington in the Western District of Washington.

1 1.1.3 Plaintiff Close and Plaintiff Larson are the natural parents of James Robert
2 Close who committed suicide while in custody at the Pierce County Detention and Corrections
3 Center ("PCDCC") in Tacoma, Washington on June 16, 2006.

4 2.2 Defendants.

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6 2.2.1 Defendant Pierce County owns and operates the PCDCC, which is located
7 in the Western District of Washington.

8 2.2.2 Defendant Pierce County Sheriff Paul Pastor is the county official with
9 final authority over policy implementation and training at the PCDCC.

10 2.2.3 Defendant Detective Steve Parr is an officer of the Lakewood Police
11 Department. He participated in the arrest of and transported James Close to the PCDCC.

12 2.2.4 Defendant Edward Correll was one of the PCDCC corrections officers
13 who received James Close at the PCDCC from Detective Parr and conducted the booking
14 process of James Close on the morning of June 16, 2006.

15 2.2.5 Defendant Joseph Gorman was one of the corrections officers who
16 conducted the booking process of James Close at the PCDCC on the morning of June 16, 2006.

17 2.2.6 Defendant Todd Klemme was the PCDCC corrections officer who
18 fingerprinted James Close.

19 2.2.7 All the actions by the individual defendants described in this Complaint
20 were taken under color of the laws of the State of Washington.

21 2.2.8 All the actions by the individual defendants described in this Complaint
22 were taken within the scope of their employment pursuant to the policies, customs and practices
23 of Pierce County.
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1 III. JURISDICTION AND VENUE

2 3.1 This Court has jurisdiction over this case under 28 U.S.C. § 1343, as plaintiffs
3 are claiming a violation of rights protected by the Fourteenth Amendment to the Constitution of
4 the United States and 42 U.S.C. § 1983.

5 3.2 Venue is properly located in this Court because the plaintiffs and at least some of
6 the defendants reside in the Western District of Washington, and the events occurred in the
7 Western District of Washington.

8 IV. FACTS

9 4.1 Events Leading to James Close's In-Custody Suicide.

10 4.1.1 On June 6, 2006, plaintiff Ralph Close, father of decedent James Close,
11 contacted Special Agent ("SA") Monte Shaide of the Federal Bureau of Investigation ("FBI"),
12 who was working with the Pierce County Violent Crime Task Force ("PCVCTF") to investigate
13 a bank robbery that occurred on March 21, 2008 involving James Close. During that contact,
14 Ralph Close told SA Shaide about James Close's role in the robbery. Ralph Close also
15 mentioned that James Close had been frustrated because he could not find a job due to prior
16 convictions, had suicidal tendencies, suffered from fetal alcohol syndrome, and had been
17 diagnosed with depression and prescribed anti-depressant medication.

18 4.1.2 Using information provided by Ralph Close, members of the PCVCTF
19 obtained a warrant from a Pierce County Superior Court on June 15, 2008 that authorized the
20 search of James Close's mobile home in Sequim, Washington.

21 4.1.3 On June 16, 2008, at approximately 8:00 a.m., the PCVCTF team
22 executed the warrant and arrested James Close. After the arrest, James Close was interviewed at
23 the Washington State Patrol office in Clallam County by SA Shaide, Detective Sergeant Todd
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1 Karr of the Pierce County Sheriff's Department, and Detective Steve Parr of the Lakewood
2 Police Department. During that interview, James Close confessed that he committed the March
3 21, 2008 bank robbery out of desperation for money. The interview ended at 8:53 a.m. After the
4 taped interview, James Close told these officers that he was bipolar, that he was not on
5 medication, and that he was prone to extreme mood swings.
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7 4.1.4 After confessing to Detective Parr, Detective Sergeant Karr, and SA
8 Shaide, in the presence of these officers, James Close expressed anger that his father, Ralph
9 Close, had informed the police of his whereabouts and involvement in the bank robbery. SA
10 Shaide and Detective Sergeant Karr also knew that James Close had been voluntarily committed
11 in Tacoma, Washington on account a suicide attempt by asphyxiation in January 2006.
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13 4.1.5 SA Shaide and/or Detective Sergeant Karr shared with the PCVCTF team
14 the information about James Close's bipolar disorder, his potential for extreme mood swings, the
15 January 2006 attempted suicide, and that he had had a violent outburst the night before on June
16 15. In addition, these officers shared with the PCVCTF team that the Close family had concerns
17 that James Close was potentially suicidal.
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19 4.1.6 At approximately 9:00 a.m., Detective Parr and Detective Sergeant Karr
20 escorted James Close to his home to identify items related to the robbery. While at the house,
21 James Close encountered his father, became enraged because he had turned him into the
22 authorities and had to be controlled by the arresting officers.
23

24 4.1.7 After the arrest, Detective Sergeant Karr filled out the PCDCC Booking
25 and Special Identification Form ("Booking Form") and made the following notations: The boxes
26 for "Mental Problems?"; "Suicide History or Tendencies?"; and "Any Signs of Depression?"
27 were all checked "Yes." Under "other remarks," Detective Sergeant Karr wrote in capital letters:

1 "HAS ATTEMPTED SUICIDE IN THE PAST. MAY BE BI-POLAR. BECAME VERY
2 ANGRY AFTER CONFESSING." At the top of the form, in large bold print, Detective Dean
3 Dumais, who was assigned to work under Detective Sergeant Karr and accompanied Detective
4 Parr, wrote: "SUICIDE WATCH." Detective Sergeant Karr later stated that Detective Dumais
5 wrote this additional warning "to make sure nobody would miss it." Detective Sergeant Karr
6 also made sure that Detective Parr understood to give the Booking Form to the PCDCC booking
7 officers. Plaintiffs attach the Booking Form as Attachment A.
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9 4.1.8 At approximately 10:00 a.m., Detective Parr and Detective Dumais took
10 James Close from his residence to Gig Harbor, Washington. Detective Dumais got out there and
11 Detective Parr drove James Close to the PCDCC. During the ride, Detective Parr saw James
12 Close cry and asked him what was wrong. In response, James Close said, "[m]y dog's gonna be
13 dead by the time I get out and knowin' my girlfriend, she's gonna be dumb enough to stand by
14 me until I get out."
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16 4.1.9 Upon arrival at the PCDCC, Detective Parr did not verbally inform any
17 booking officer that the arresting officers and the Close family were concerned about the risk
18 that James Close would commit suicide, and that James Close was at times morose during the
19 ride.
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21 4.1.10 At 11:48 a.m., James Close was booked by Officers Joseph Gorman and
22 Edward Correll at the PCDCC. As part of that process, Officers Gorman and Correll received
23 and looked at the Booking Form with the "SUICIDE WATCH" designation and the other suicide
24 warnings described above. Officers Gorman and Correll later acknowledged during a
25 subsequent Pierce County Sherriff's Department internal investigation into the suicide ("the
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1 internal investigation”), that they confirmed with James Close that he had attempted suicide in
2 the previous six months.

3 4.1.11 Officer Correll was the first Pierce County corrections officer to make
4 contact with James Close and voluntarily took on the informal role of the “patdown” officer in
5 the booking process. This consisted of a “pat/search” security check of James Close’s body for
6 contraband. Although Officer Correll later claimed during the internal investigation that he did
7 not see the “SUICIDE WATCH” designation, he has admitted that he reviewed the arresting
8 officer’s Booking Form, saw a “notation that he had attempted suicide in the past” and that “he
9 may . . . have some bipolar issues,” and “noticed that there were some things about suicide on
10 there.”
11

12 4.1.12 Officer Correll also assumed responsibility for asking James Close
13 medical screening questions on the Inmate Health Screening Form. In purported response to
14 these questions, Officer Correll checked “No” to the boxes corresponding to “Suicidal Now,”
15 “Appears Psychotic,” or “Suicide Attempt in Last 2 Months.” On this form Officer Correll did
16 indicate that James Close had a “Mental Health Diagnosis” of “Bi-Polar,” but Officer Correll did
17 not call a booking nurse or mental health professional to conduct a mental health evaluation.
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19 4.1.13 During this process, Officer Correll had the duty to “dress” James Close
20 either in gray clothing appropriate for the general population or in a “suicide smock,” which
21 would indicate he was to be put in a suicide observation cell. In deliberate disregard of the
22 information he had, Officer Correll opted to dress James Close in grays.
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24 4.1.14 Officer Gorman, as the “booking officer,” conducted the next step of the
25 booking process. Officer Correll stated in the internal investigation that he conferred with
26 Officer Gorman and “pointed out what the arresting officer had written” before passing James
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1 Close to Officer Gorman to continue the booking process. Officer Gorman admittedly reviewed
2 the remainder of the Booking Form, although in the internal investigation he later claimed not to
3 see the bold-print "SUICIDE WATCH" warning at the top. Officer Gorman specifically noted
4 that the boxes for "Mental Problems?"; "Suicide History or Tendencies?"; and "Any Signs of
5 Depression?" were all checked "Yes," and that in the "other remarks" box that the arresting
6 officer had written "HAS ATTEMPTED SUICIDE IN THE PAST. MAY BE BI-POLAR.
7 BECAME VERY ANGRY AFTER CONFESSING." In deliberate disregard of this danger,
8 Officer Gorman did not call for a mental health professional or place James Close in a suicide
9 observation cell.
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11 4.1.15 At the PCDCC booking desk on June 16, 2006, there was no mental health
12 professional available to consult with James Close. According to Officer Gorman, there was
13 never a mental health professional available at the booking desk and a mental health care
14 professional would "probably not" be available for him to contact "because they don't answer
15 their phones" or they are "busy" "in their offices."
16

17 4.1.16 As part of the booking process, Officer Josef Crews completed the
18 PCDCC's "Initial Housing Assignment," a schematic for placing all detainees within the
19 detention facility according to security, medical, mental health and other concerns. Officer
20 Crews completed this schematic and elected not to place James Close in the "Suicide
21 Observation Cell." Instead, Officer Crews placed James Close in a "level 2 environment." A
22 "level 2 environment" is two-person cell at the PCDCC, and a classification that is informed only
23 by security issues associated with a detainee's criminal charge and not by any mental health
24 criteria. When James Close got to the cell, his designated cellmate was not present.
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1 4.1.17 At approximately 1:00 p.m., after the booking process was complete, the
2 PCDCC issued James Close blankets, towel and a sheet, and transferred him to a cell in the
3 PCDCC's 3-West C wing that housed the "level 2 environment." Officer Tim Peeler, who
4 placed James close in his cell, observed that he was "quiet" and had a "1000 yard stare."

5 4.1.18 At 2:55 p.m., Jerry Coombs, the cellmate assigned to James Close's cell,
6 was returned there. When Officers Bryan Buckingham and Jonathan Madden opened the cell
7 door, they discovered James Close hanging from his bed sheet without a pulse.
8

9 4.1.19 After unsuccessful attempts to use CPR, James Close was transported to
10 Tacoma General Hospital. He never regained consciousness despite some indication that he
11 aspirated shortly before Tacoma Fire and Rescue arrived at 3:05 p.m.
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13 4.1.20 On June 17, 2008, at 6:50 p.m., life support to preserve James Close's
14 organs was discontinued and he was pronounced dead.

15 4.2 Defendants Pierce County and Sheriff Pastor Knew That Protocols For Inmate
16 Health Care Evaluation and Booking at the PCDCC Did Not Meet National
 Standards and Were Likely to Result in Preventable Suicides.

17 4.2.1 At the time of James Close's suicide, Pierce County was required to
18 consider National Commission on Correctional Health Care (NCCHC) standards in establishing
19 health care standards for PCDCC.
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21 4.2.2 At the time of James Close's suicide, Pierce County was required to have
22 at least one licensed nurse practitioner on site at the PCDCC to assess prisoners during the
23 booking process and make any medical professional evaluation as necessary.

24 4.2.3 At the time of James Close's suicide, Pierce County was to have
25 developed and implemented a detainee classification system during the booking process that
26 called for staff to ask questions about mental health issues and suicide risk and properly record
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1 detainee answers to these questions. Pierce County was also required to provide training to staff
2 regarding mental health and suicide risk assessment, was required to allocate sufficient staffing
3 for this procedure, and was prohibited from using officers to perform booking procedures who
4 had not been trained in such protocols.

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6 4.2.4 At the time of James Close's suicide, and well before, Pierce County and
7 Sheriff Pastor were aware of the following deficiencies at the PCDCC: (A) The PCDCC
8 suffered from deficient nurse staffing, a shortage that resulted in the PCDCC not meeting the
9 NCCHC standards for performing mental health screening and evaluations. (B) The PCDCC
10 fell below the NCCHC standard for mental health screening and evaluation, with an identified
11 need to develop multiple mental health systems including training booking officers to recognize
12 signs of mental health problems, coordination with arresting officer comments to conduct intake
13 screening, and asking questions on detainee past history. (C) The PCDCC did not meet the
14 NCCHC standards with respect to on-going training for suicide prevention.
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16 4.2.5 In deliberate disregard of the dangers they posed, Pierce County and
17 Sheriff Pastor allowed these deficiencies to persist, and on June 16, 2006, they led to James
18 Close's death.

19 V. CLAIMS

20 5.1 The above-described acts and omissions of the individual defendants amount to
21 deliberate indifference to the known risk that James Close would commit suicide, leaving his
22 parents without their son. The loss of James Close's life due to this deliberate indifference
23 deprived the plaintiffs of their liberty interest in the companionship of their son without due
24 process of law, in violation of their rights under the Fourteenth Amendment to the Constitution
25 of the United States and 42 U.S.C. § 1983.
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1 5.2 Defendants Pierce County and Sheriff Pastor were on notice by September 2005
2 that the PCDCC suffered from deficient nurse staffing, and that this staff shortage resulted in its
3 not meeting the NCCHC standards for performing mental health screening and evaluations. By
4 failing to remedy this known shortage, Defendant County pursued policies that were deliberately
5 indifferent to the risk of suicide by pretrial detainees like James Close who required mental
6 health evaluation but did not receive it, which resulted in his preventable suicide in violation of
7 the parent-plaintiffs' rights under the Fourteenth Amendment to the Constitution of the United
8 States and 42 U.S.C. § 1983.

10 5.3 Defendants Pierce County and Sheriff Pastor were on notice by September 2005
11 that the PCDCC did not meet NCCHC standards for mental health screening and evaluation,
12 including the mandate that PCDCC needed to establish multiple mental health systems such as
13 training for booking officers to recognize signs of mental health problems and to coordinate with
14 arresting officer comments to conduct intake screening. Defendants Pierce County and Sheriff
15 Pastor were also on notice by September 2005 that the PCDCC did not meet the NCCHC
16 standards with respect to on-going training for suicide prevention. These failures to develop
17 protocols and/or train corrections officers in such protocols amounted to deliberate indifference
18 to inmates like James Close who had serious mental health concerns, including the known risk of
19 suicide, which resulted in his preventable suicide in violation of the parent-plaintiffs' rights
20 under the Fourteenth Amendment to the Constitution of the United States and 42 U.S.C. § 1983.

23 5.4 Absent the acts and omissions of the individual defendants and the staffing and
24 training deficiencies on the County's part, James Close's suicide on June 16, 2006 would not
25 have occurred.
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VI. RELIEF REQUESTED

WHEREFORE, the plaintiffs request relief as follows:

6.1 Compensatory damages;

6.2 Punitive damages from any individual defendant found to have caused James Robert Close's death through deliberate indifference to constitutional rights.

6.3 Costs, including reasonable attorneys' fees pursuant to 42 U.S.C. § 1988.

6.4 Such other relief as may be just.

DATED this 16 day of January, 2009.

MacDONALD HOAGUE & BAYLESS

By



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ATTACHMENT A

DATE OF BIRTH: 12/21/75

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